International Journal of Medicine, Nursing & Health Sciences (IJMNHS) ® (IJMNHS.COM)

Perceived Factors Influencing Preventive Practice of Cholera Among Mothers Attending Infant Welfare Clinic in Ekiti State University Teaching Hospital, Ado-Ekiti, Ekiti State, Nigeria

Author(s), OTUGBOYEGA, Olaide Oluwayemisi,
OTUGBOYEGA, Joseph Olusoji, AFOLAYAN, Sunday Olusola,
FALADE, Oluwabusayo Rebecca,

Abstract:

This study examined perceived factors influencing preventive practices of cholera among mothers attending infant welfare clinic in Ekiti State University Teaching Hospital Ado Ekiti, Ekiti State. This study utilized survey form of non-experimental descriptive research design. The research was carried out in Ekiti State University Teaching Hospital (EKSUTH) Ado Ekiti among mothers attending infant welfare clinic. The sample size was determined using Taro Yamane's formula which yielded sample size of 80. Simple random sampling technique was used to select the sample size. A well-structured questionnaire was used as the instrument for data collection which consisted of five sections A, B, C, D and E. The validity of instrument was established by experts of Tests and Measurement through face and content validity. Descriptive and inferential statistics were used to analysed the data collected and hypotheses were tested at 0.05 level of significance. The result of the study shows that some misconceptions about the causes of cholera exist among respondent. Most of the respondents have good knowledge about the causative agent of cholera, preventive practices, factors influencing the practices and preventives measures. However, respondent still have some misconceptions and lack knowledge on preventive practices of cholera as some attributes use of unclean water, doing open

defecation, opening of leftover food as preventive practices of cholera. It was recommended among others that government should create awareness to improve people's knowledge about cholera infections.

Keywords: Perceived Factors, Preventive Practice, Cholera, Mothers,

2

**International Journal of Medicine, Nursing & Health Sciences (IJMNHS) ®
(IJMNHS.COM)**
Email: editor.ijmnhs@gmail.com   editor@ijmnhs.com Website: **ijmnhs.com**

Published By

About Author

Author(s): OTUGBOYEGA, Olaide Oluwayemisi
Ekiti State University Teaching Hospital,
School of Nursing, Ado – Ekiti, Nigeria.
olaideotugboyega@gmail.com

OTUGBOYEGA, Joseph Olusoji
Environmental Management and Toxicology Department,
Faculty of Science,
Federal University, Oye, Ekiti State, Nigeria.

AFOLAYAN, Sunday Olusola
Ekiti State University Teaching Hospital,
School of Nursing, Ado – Ekiti, Nigeria.
sundayolus471@gmail.com

and

FALADE, Oluwabusayo Rebecca
tosinopeyemi944@gmail.com

3

**International Journal of Medicine, Nursing & Health Sciences (IJMNHS) ®
(IJMNHS.COM)**
Email: editor.ijmnhs@gmail.com   editor@ijmnhs.com   Website: **ijmnhs.com**

Published By

Introduction

Cholera is a real and ongoing danger to the health and welfare of people everywhere (Halima, 2018). Because of its global impact and epidemic potential, the disease has played a pivotal role in public health throughout history (Deen, et al 2020). Cholera is still a problem in many parts of the world and is a sign of social injustice and underdevelopment. Millions of people have been afflicted by cholera pandemics since the early 1800s (Debes, 2018). Annually, it is anticipated that between 21,000 and 143,000 people would perish from cholera infections over the world (WHO, 2019). Vibrio cholerae bacteria can be found in the faeces of infected people for 1-10 days after infection, however the vast majority of patients show no symptoms. The bacteria are then released back into the environment, where they can infect other people (Anetor & Abraham, 2018).

An intestinal infection with the bacteria Vibrio cholerae serogroup 01 or 0139 results in the acute diarrheal illness known as cholera. Each year there are around 2.9 million new cases and 95,000 fatalities. Symptoms may be little or nonexistent, but the infection can be rather serious. Cholera can cause severe symptoms such as watery diarrhea, vomiting, and leg cramps in about 10% of those infected. Dehydration and shock result from the rapid loss of bodily fluids in these persons. Without medical attention, death can occur in as little as an hour. After ingesting cholera bacterium, a person may not experience symptoms for several days. However, this time frame might vary from a few hours to five days (CDC, 2013). Cholera is an intestinal bacterial infection brought on by specific vibrio cholerae strains. (V. Cholerae). Oral intake of the bacteria, which is common because it is present in food and water, can cause infection. The hallmark symptoms of cholera, including acute watery diarrhoea and vomiting, are caused by enterotoxins (toxins that act in the gastrointestinal tract) produced by V. cholerae after ingestion (Mohammed, 2017).

Parts of Africa, Asia, the Middle East, and South and Central America all have endemic populations. Disruptions to public sanitation systems, such as those caused by war or civil disturbance, are a common cause of outbreaks in endemic regions. Disruptions to the natural order, such as those caused by earthquakes, tsunamis, volcanic eruptions, landslides, and floods, can also play a role in sparking epidemics (Orimbo, et al 2018). Multiple nations in Africa and Asia have reported cholera outbreaks in 2021, per a WHO study. There are currently major epidemics in Bangladesh, Nigeria, and Niger. In 2014, cholera was responsible for 7,734 deaths in Kenya. Between 1994 and 2003, there were 20 cases of cholera reported per 100,000 persons annually; between 2004 and 2013, that number dropped to 6 occurrences per 100,000. (2015). Prevention is much more cost-effective and preferable to treatment when it comes to cholera control.

Cholera is a watery diarrheal sickness that naturally occurs in brackish-fresh water and can be fatal if left untreated or if a person doesn't get medical attention quickly enough (Talaei, et al., 2018). After a natural calamity, like a typhoon, flood, or earthquake, cholera can suddenly and rapidly spread throughout a community. Cholera is mostly transmitted by contaminated water, thus any disruption to the water distribution system, poor hygiene conditions, or lack of sanitation facilities during a natural catastrophe increases the risk of an outbreak (Mutreja & Dougan, 2020). Cholera is known to induce severe diarrhoea that can kill in less than 30 minutes. In instance, it can wipe out an entire community in a matter of hours or a day and

infect a sizable percentage of the locals (WHO, 2018). Symptoms of a V. cholerae infection include severe abdominal pain, nausea, vomiting, and diarrhea, which can quickly lead to dehydration. Extreme fluid volume depletion and metabolic acidosis lead to these losses, which in turn can lead to circulatory collapse and death (Kaiser & Foster, 2019). Cholera symptoms can range from mild to severe, but they always begin suddenly and include watery diarrhea, dry mouth, dehydration, rapid heartbeat, thirst, decreased urination, and nausea and vomiting (Debes, 2018).

When sanitation is inadequate, cholera outbreaks are more likely to occur. Poor sanitation and hygiene are major contributors to the spread of cholera, which, according to the research of Orimbo et al. (2018), is ingested through contaminated food or water. Raw or undercooked seafood, especially crabs and other shellfish found in estuaries, can also introduce the parasite into the body. Another typical route of infection is from poorly washed veggies irrigated with dirty water. There is a significant risk of faecal contamination in unprotected water sources, such as rivers, shallow wells, and other untreated water sources. During the rainy season, when debris flows into lakes and rivers and people wash their faces in them, this is especially true. Due to a lack of sanitary facilities, people are forced to defecate in the open, and this has contaminated nearby water supplies (Orimbo et al, 2018).

The 1991 cholera pandemic, which caused 59,478 cases and 7654 fatalities, is the most prominent of Nigeria's many cholera outbreaks with high case fatality rates (CFRs); the CFR of 12.9% reported for that outbreak remains the highest for the country to this day. Nigeria has the second highest daily under-five mortality rate in the world, with 2,300 children dying before their fifth birthdays every day (WHO, 2018). The smallest children are most susceptible to cholera, with incidence being highest in the first two years of life, however declining as the kid grows older. Infection is widespread and epidemics frequently occur in Nigeria. Water Aid Nigeria reported in 2018 that 33% of the country's population, or 60 million people, do not have access to clean water, 67% of the population, or over 120 million people, do not have access to a decent toilet, and 26% of the population, or about 47 million people, practise open defecation.

One of the key causes contributing to the rise in cholera prevalence was identified as moms' lack of information about the disease. According to the research conducted by Tom et al. (2018) in Kenya, 63.1% (n = 152) of respondents classified cholera as a cause of diarrhoea and vomiting, while 30.7% (n = 74) defined it as diarrhoea similar to rice water. However, just 5.4% said that cholera might be fatal within hours if left untreated due to dehydration.

Researchers in Ibadan found that 204 people (47.8%) agreed that impoverished countries are where you're more likely to encounter cholera. Nearly eighty percent of people polled got the identification of cholera as an infectious disease right. The most common symptoms of cholera sickness, as reported by 415 (97.2%) patients, were watery stools and (96.3%) vomiting. Among 305 respondents, 71.4% believe that cholera can be spread by contact with contaminated food or water, while 57.6% believe that it is spread through insect bites, and 50.5% believe that it can be spread through contact with contaminated hands. There were 406 people (95.1%) who made the connection between dirty environments and cholera, and 71.4% who linked consuming cold or stale food to the disease. Good personal cleanliness was identified by 95.6% of respondents as the most effective method of preventing cholera,

whereas the stool test was identified by 60% of respondents as the most effective method of detecting the disease. 95.3% of respondents had good knowledge about cholera, whereas 4.7% had low knowledge, as indicated by the distribution of the composite score for knowledge of cholera (Elimian, et al., 2020).

Its high frequency among children can be attributed in part to parents' lack of understanding on how to ensure that their children have access to clean water, a safe environment, and proper sanitation (Anetor & Abraham, 2018). Sustaining disease control requires a massive public health promotion programme that zeroes in on tried and true cholera prevention strategies. Therefore, this study examined perceived factors influencing preventive practices of cholera among mothers attending infant welfare clinic in Ekiti State University Teaching Hospital Ado Ekiti. Specifically, the study:

1. assessed the level of knowledge on preventive practices of cholera among mothers attending infant welfare clinic;
2. determined the level of practices of prevention of cholera among mothers attending infant welfare clinic;
3. identified the preventive measures of cholera adopted by mothers attending infant welfare clinic; and
4. determined the perceived factors influencing the preventive measures on cholera among mothers attending infant welfare clinic in Ekiti State University Teaching Hospital Ado Ekiti.

Research Hypotheses

Ho1: There is no significant association between the level of knowledge of mothers attending infant welfare clinic and their level of preventive practices on cholera

Ho2: There is no significant association between the level of education and the preventive measures adopted by the mothers attending infant welfare clinic in Ekiti state university teaching hospital.

Materials and Methods

This study utilized survey form of non-experimental descriptive research design to assess the knowledge and perceived factors influencing preventive practice of cholera among mothers attending infant welfare clinic in Ekiti State University Teaching Hospital, Ado Ekiti, Ekiti State. The research was carried out in Ekiti State University Teaching Hospital (EKSUTH) Ado Ekiti among mothers attending infant welfare clinic. EKSUTH is situated along Adebayo, Opopogboro road, in Ado Local Government area in Ekiti central senatorial district. The target population included all mothers attending infant welfare clinic in Ekiti State University Teaching Hospital, Ado Ekiti. The sample size for this study comprises of mothers attending infant welfare clinic in Ekiti State University Teaching Hospital, Ado Ekiti, Ekiti State. The sample size was determined using Taro Yamane's formula which yielded sample size of 80. Simple random sampling technique was used to select the sample size.

A well-structured questionnaire was used as the instrument for data collection which consisted of five sections A, B, C, D and E. Section A sought for respondents' demographic data while section B consisted of questions on the level of knowledge on preventive practices of mothers on cholera. Section C consisted of questions on factors influencing preventive practices of cholera, section D consisted of questions on knowledge of mothers on the level of

practices of prevention of cholera, while section E consisted of questions assessing the preventing measures of cholera adopted by mothers.

The validity of instrument was established by experts of Tests and Measurement through face and content validity. Data were collected through the administration of questionnaires by the researcher. Items of the questionnaires were interpreted to mothers who cannot read or understand English Language. The filled copies of the questionnaire were collected back on the spot to avoid loss. The data collected were sorted out manually and analysed using Statistical Package for Social Sciences (SPSS) version 25. Descriptive and inferential statistics were used to analysed the data collected and hypotheses were tested at 0.05 level of significance.

Results

Table 1: Frequency Analysis of Demographic Data

CATEGORY	FREQUENCY	PERCENTAGE
AGE (IN YEARS)		
20-25	39	48.8
25-30	2	2.5
31-40	33	41.3
41-50	5	6.3
MARITAL STATUS		
SINGLE	3	3.8
MARRIED	76	95.0
DIVORCED	1	1.3
ETHINICITY		
YORUBA	70	87.5
IGBO	8	10.0
HAUSA	0	0
OTHERS	2	2.5
RELIGION		
CHRISTIANITY	69	86.3
ISLAM	11	13.8
TRADITIONAL	0	0
OTHERS(SPECIFY)	0	0
OCCUPATION		
CIVIL SERVANT	23	28.0
TRADER	32	40
HAIRDRESSER	6	7.5
OTHERS(SPECIFY)	19	23.8
NUMBER OF CHILDREN		
1	27	33.8
2	34	42.5
3	16	20.0
4 AND ABOVE	3	3.8
LEVEL OF EDUCATION		
PRIMARY	2	2.5
SECONDARY	11	13.8
TERTIARY	66	82.5
NO FORMAL EDUCATION	1	1.3

The table above shows that 48.8% (39) respondents are between the age of 20-25,2.5% (3) respondents is between the age of 25-30, 41.3% (33) respondents is between the age of 31-40 and 6.3% (5) respondents are between the age of 41-50. Marital status of the respondent showed that 3.8% (3) respondents are single, 95.0% (76) respondents are married, 1.3% (1) respondent is divorced. The respondent's ethical status showed that 87.5% (70) respondents are Yoruba, 10.0% (8) respondents are Igbo, 2.5% (2) respondent are others. Religion status of the respondent health showed that 86.3% (69) respondents are Christian, 13.8% (11) respondents are practicing Islamic religion. Respondent's occupational status showed that 28.0% (23) are civil servant, 40% (32) respondent is trader, 7.5% (6) respondent are hairdresser, 23.8% (19) are others. Respondent's number of children showed that 33.8% (27) respondent have 1 child, 40.5% (34) respondent have 2 children, 20.0% (16) respondent have 3 children, 3.8% (3) respondent have 4 and above. Respondent's educational status background showed that 2.5% (2) respondents have primary education, 13.8% (11) respondents have secondary education, 82.5% (66) respondents have tertiary education and 1.3% (1) respondent have no formal education.

Table 2: Knowledge on preventive practices of cholera among mothers

QUESTIONS	FREQUENCY	PERCENTAGE
Cholera can be prevented through		
Hand washing	66	82.5
Open defecation	2	2.5
Use of unclean water	11	13.8
Opening of leftover food	1	1.3
Cholera is caused by?		
Bacteria	63	78.8
Virus	12	15.0
Fungi	5	6.3
Cholera prevention helps to have?		
Good health	72	90.0
Poor health	8	10.0
Cholera is caused due to		
Poor hygiene	72	90.0
Clean environment	4	5.0
Good hygiene	4	5.0
Eating well cooked food		
Build immunity	33	41.3
Destroy immunity	4	5.0
Provide good health	41	51.3
All of the above	2	2.5

The table above showed that 82.5% (66) respondents that hand washing can prevent cholera, 2.5% (2) respondents said that open defecation prevent cholera, 13.8% (11) respondent said use of unclean water prevent cholera, 1.3% (1) respondent said opening defecation prevent cholera. 78.8% (63) respondents said that cholera is caused by bacteria, 15.0% (12) said that it is caused by Virus, 6.3% (5) respondent said that it is caused by Fungi. 90.0% (72)

respondents said cholera prevention helps to have good health while 10.0% (8) respondents said cholera prevention helps to have poor health. 90.0% (72) respondents said that cholera is caused due to poor hygiene, 5.0% (4) respondents said it is caused due to clean environment and 5.0% (4) said that it is caused due to good hygiene. 41.3% (33) respondents said eating well cooked food build immunity, 5.0% (4) respondents said it destroy immunity, 51.3% (41) respondents said it provide good health and 2.5% (2) respondents said all of the above.

Table 3: Factors influencing preventive practices on cholera

QUESTIONS	STRONGLY AGREE F %	AGREE F %	DISAGREE F %	STRONGLY DISAGREE F %
Poor sanitation	51 63.8	15 18.8	6 7.5	8 10.0
Unavailability of clean water	40 50.0	29 36.3	7 8.8	4 5.0
Inadequate health education from health practitioner	26 32.5	33 41.3	16 20.0	5 6.3
Educational Status	21 26.3	33 41.3	19 23.8	7 8.8
Low economic income	27 33.8	20 25.0	18 22.5	15 18.8

From the above table, 63.8% (51) respondent strongly agreed that poor sanitation can influence preventive practices on cholera, 18.8% (15) respondents agreed that poor sanitation can influence preventive practice of cholera,7.5% (6) respondents disagreed that poor sanitation can influence preventive practice of cholera, 10.0% (8) respondents strongly disagreed that poor sanitation can influence preventive practices of cholera. 50.0% (40) respondents strongly agreed that unavailability of clean water supply can influence preventive practice of cholera, 36.3% (29) respondents agreed that unavailability if clean water supply can influence preventive practices of cholera, 8.8% (7) respondents disagreed that unavailability of clean water supply can influence preventive practice of cholera, 5.0% (4) respondents strongly disagreed that unavailability of clean water supply can influence preventive practice of cholera. 32.5%(26) respondents strongly agreed that inadequate health education from health practitioner can influence preventive practice of cholera, 41.3%(33) respondents agreed that inadequate health education from health practitioner can influence preventive practice on cholera, 20.0%(16) respondents disagree that inadequate health education from the health practitioners can influence preventive practice of cholera, 6.3%(5) strongly disagree that inadequate health education from health practitioners can influence preventive practice of cholera.

About 26.3% (21) respondent strongly agreed that educational status can influence preventive practices of cholera, 41.3% (33) respondents agree that educational status can influence preventive practices of cholera, 23.8% (19) respondents disagree that educational status can influence preventive practices of cholera, 8.8% (7) respondents strongly disagree that educational status can influence preventive practice of cholera. 33.8%(27) respondents strongly agreed that low economic income can influence preventive practice of cholera, 25.0%(20) respondents strongly agreed that low economic income can influence preventive practices of cholera, 22.5%(20) respondents agreed that low economic income can influence

preventive practices of cholera, 22.5%(18) respondents disagreed that low economic income can influence preventive practices of cholera, 18.8%(15) respondents strongly disagreed that low economic income can influence preventive practice of cholera.
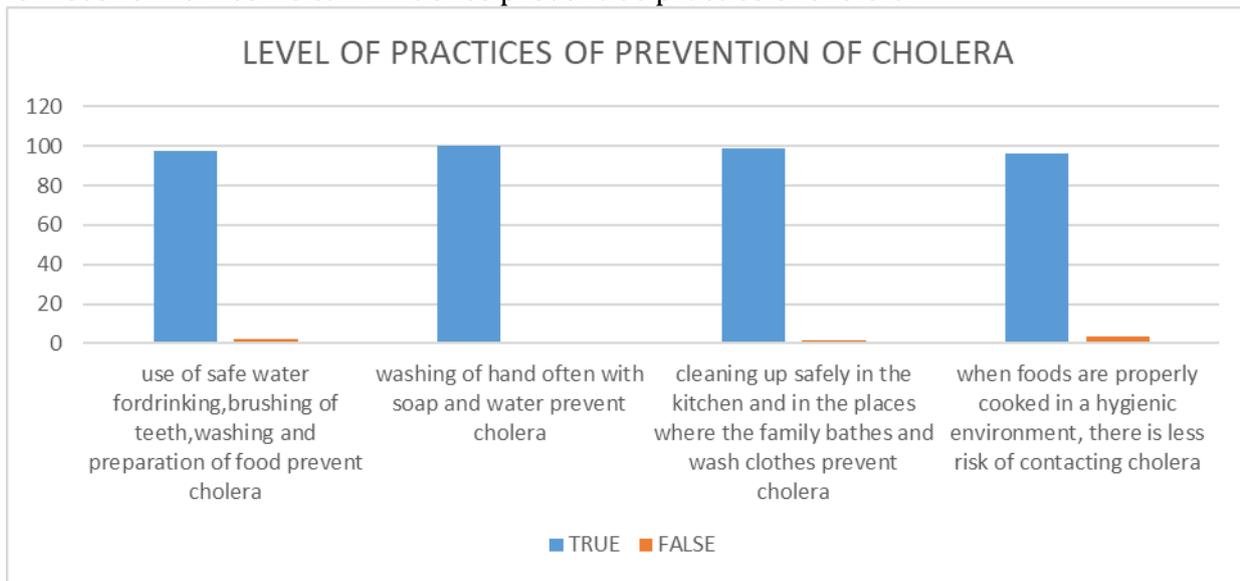

Figure 1: Level of practices of prevention of cholera

The chart above showed that 97.5% (78) respondents agreed that use of safe water for drinking, brushing of teeth, washing and preparation of food prevent cholera while 2.5% (2) disagreed. 100% (80) respondents agreed that washing of hand often with soap and water prevent cholera. 98.8% (79) respondents agreed that cleaning up safely in the kitchen and in places where the family bathes and wash clothes prevent cholera while 1.3% (1) disagreed. 96.3% (77) agreed that when foods are properly cooked in a hygienic environment that there is less risk of contacting cholera while 3,8% (3) respondents disagreed.

Table 4: Preventive measures adopted by mothers

QUESTIONS	STRONGLY AGREE F %	AGREE F %	DISAGREE F %	STRONGLY DISAGREE F %
Treatment of water before usage can reduce the incidence of cholera	51 63.8	25 31.25	3 3.8	1 1.3
Eating of well wash food and blended fruit prevent cholera	36 45.0	37 46.3	7 8.8	1 1.3
Covering of leftover food or drink can reduce the occurrence of cholera	41 51.3	32 40.0	6 7.5	1 1.3
Not using water for cooking for children without knowing the source	32 40.0	30 37.5	10 12.5	8 10.0

From the above table, 63.8% (51) respondent strongly agreed that treatment of water before usage can reduce the incidence of cholera, 31.25% (25) respondents agreed that treatment of

water before usage can reduce the incidence of cholera, 3.8% (3) respondents disagree that treatment of water before usage can reduce the incidence of cholera, 1.3% (1) respondents strongly disagreed that treatment of water before usage can reduce the incidence of cholera. 45.0%(36) respondents strongly agree that eating of well wash food and blended fruit prevent cholera, 46.3% (37) respondents agree that eating of well wash food and blended fruit prevent cholera, 8.8% (7) respondents disagree that eating of well wash food and blended fruit prevent cholera, 1.3% (1) respondent strongly disagree that eating of well wash food and blended fruit prevent cholera.

About 51.3% (41) respondents strongly agree that covering of leftover food or drink can reduce the occurrence of cholera, 40.0% (32) respondents agree that covering of leftover food or drink can reduce the occurrence of cholera, 7.5% (6) respondents disagree that covering of leftover food or drink can reduce the occurrence of cholera, 1.3% (1) respondent strongly disagreed that covering of food can reduce cholera. 40.0% (32) respondents strongly agreed that not using water for cooking for children without knowing the source is part of preventive measures adopted in prevention of cholera, 37.5% (30) respondents agreed that not using water for cooking for children without knowing the source is part of preventive measures adopted in prevention of cholera, 12.5% (10) respondents disagreed that not using water for cooking for children without knowing the source is part of preventive measures adopted in prevention of cholera, 10.0% (8) respondents strongly disagreed that not using water for cooking for children without knowing the source is part of preventive measures adopted in prevention of cholera.

Test of Hypotheses

Hypothesis 1: There is no significant association between the level of knowledge of mothers attending infant welfare clinic and their level of preventive practices on cholera.

Table 5: Chi-square analysis of the association between the level of knowledge of mothers attending infant welfare clinic and their level of preventive practices on cholera

Variables	Level of preventive practices of cholera			Df	X^2tab	X^2cal
Level of knowledge	True	False	Total			
Hand washing	66	0	66			
Open defecation	2	0	2			
Use of unclean water	10	1	11			
Opening of leftover food	1	0	1	3	2.3534	6.352
Total	79	1	80			

From the above table, the total number of respondents are 80; Degree of freedom (df) is 3. The calculated value (x^2cal) is 6.352, then it is greater than the table value (x^2tab) (2.3534), it is significant. Hence, the hypothesis is rejected. Therefore, there is significant association between the level of knowledge of mothers attending infant welfare clinic and their level of preventive practices on cholera.

Hypothesis 2: There is no significant association between the level of education and the preventive measures adopted by the mothers attending infant welfare clinic in Ekiti state university teaching hospital.

Table 6: Chi-square analysis of the association between the level of education and the preventive measures adopted by the mothers attending infant welfare clinic

Variables Level of education	Preventives measures adopted by mothers					df	X²tab	X²cal
	SA	A	D	SD	Total			
Primary	2	0	0	0	2			
Secondary	4	7	0	0	11	6	1.9432	7.173
Tertiary	44	19	3	0	66			
No formal education	1	0	0	0	1			
Total	51	26	3	0	80			

From the above table, the number of respondents is 80; Degree of freedom (df) is 6, the calculated value (x²cal) is 7.173 then is greater than the table value (x²tab) (1.9432), it is significant. Hence it is rejected. Therefore, there is significant rassociation between the level of education and the preventive measures adopted by the mothers attending infant welfare clinic in Ekiti state university teaching hospital.

Discussion of Findings

Findings from this study show that the knowledge of respondents on the cause of cholera is good, this may be because most of the respondents have tertiary level of education. This finding is in contrasts with the research done in Jazan city on knowledge, attitude and practice study regarding cholera among the people in Jazan city, in 2021, which their level of knowledge statistically was significantly different from their educational level. This finding is in lines with the study carried out in KSA city in Kenya by Orimbo, et al (2018) in which revealed a significant relationship between level of knowledge and level of education, where more educated individuals had a better level of knowledge about cholera. Also, about 89.9% of the respondents have good knowledge on the preventive practices of cholera this may also be due to their level of education. This is in contrasts with the study conducted in Iran, by Talaei, et al (2018), which 35.7% of the mothers have good knowledge about cholera preventives practices.

The findings from this study shows that 70%of the respondent are traders, as a result of this many of them indicated that they are of low economic income this may have influence on their preventives practices of cholera as many of the respondent are unable to buy treatments for water, build adequate toilet and also eat adequate meals. This finding is line with the study conducted in Haiti by Guillaume, et al (2019), some women about 17% indicated that poor access to needed resources contributed to inconsistent use of treated water or treatment products. Also, participant (60%) reported little to no changes in the defecation practices due to lack of latrines for the continue behavior and financial constraint as main barrier to their construction.

The findings from this study shows inadequate health education from health practitioner which influences preventives practices of cholera due to their busy time with their business

and the health practitioners are unable to reach them. This is in contrasts with the study carried out in Kenya, by Beasley and Amir (2018), which says that the health facilities lack the much-needed effective response capacity in terms of testing and confirmation of cases and lack of laboratory reagents which can be so devastating to the outbreak management and may hamper rapid action in cholera prevention.

The finding from this research shows that 90% of the mothers have a high level of practices towards cholera prevention while 10% of the mothers have low level of cholera prevention. This is in contrasts with the study conducted in Kenya by Tom, et al (2018), in which there was low level of practices in cholera prevention, there was low water treatment practice and since contaminated drinking water is probably the most common cause of cholera especially in poor and vulnerable communities.

This finding shows that 86.3% of the respondents have a high level of practices of preventions of cholera, by washing of hands often with soap and water to prevent cholera, use of safe water for drinking, brushing of teeth, washing and preparation of food to prevent cholera while 15% of the respondent have low level of practices of preventions of cholera. This is in line with the study carried out in Kenya by Ali (2017), in which 95% of the respondents response that the key ways of prevention of cholera disease include drinking and use of safe water and hand washing with soap.

This finding shows that 63.8% of the respondents adopt treatment of water before usage and eating of well wash food and blended fruit as a measure for preventions of cholera while 36.2% of the respondent does not adopt treatment of water before usage and eating well wash food and blended fruit as measure for prevention of cholera. This is in lines with the study by Gazin, et al (2017) on control of cholera epidemic which the preventives measures adopted by respondents are cleaning of home, well cooked food, treatment of water and collecting it in a clean container.

Implications to Public Health

The result of the study shows that some misconceptions about the causes of cholera exist among respondent. Therefore, Nurses should identify areas of misconceptions among community and shed more light to address their misconceptions. Also, the use of safe water and hygienic practices is still low. However, Nurses should emphasize on important of using safe water, treatment of water and hygienic practices like washing of hands before and after toileting, cleaning of the environment, hygienic preparation of foods.

Conclusion

Most of the respondents have good knowledge about the causative agent of cholera, preventive practices, factors influencing the practices and preventives measures. However, respondent still have some misconceptions and lack knowledge on preventive practices of cholera as some attributes use of unclean water, doing open defecation, opening of leftover food as preventive practices of cholera.

Recommendations

Base on the findings from the study, the researcher therefore recommended the following;

1. Government should create awareness to improve people's knowledge about cholera infections.

2. Government should make compulsory an environmental sanitation day for the society and also makes it effective
3. Nurses should do periodical health education to enlighten the mothers
4. Nurses should enlighten the society so as to know the preventive measures to be taking against cholera disease.
5. Mothers should be encouraged to bring their child to hospital immediately they notice the signs and symptoms of cholera.

References

Anetor, G.O. & Abraham F.I. (2018). Knowledge of Cholera and its prevention amongst Urban residents of a district in Abuja: The pivotal role of Health Education. *Journals on Health Science,* 20(12), 98-105.

Beasley A.O. & Amir, L.H. (2018). Infant feeding, poverty and Human Development. *Journal on Health science.* 2(14), 30-40).

Curtis, V.O. & Cairncross, S.O. (2019). Effect of Washing Hands with soap on cholera risk in the community. *Journals on Health Wellness*, 3(27), 5-10.

Debes, A.K. (2018). *Assessment of Efficient and Sustainable Tools for Cholera Detection and Intervention in low Resources Settings*. Johns Hopkins University.

Deen, J.O., Mengel, M.A. & Clements, J.D. (2020). Epidemiology of Cholera. 38(7), 31-40.

Elimian K.O., Mezue S.O. & Oyebanji O.O. (2020). What are the drivers of recurrent cholera transmission in Nigeria? Evidence from scoping review. *Journals on public Health*. 20(4), 5-12.

Gazin, P.O., Barrais, R.O. & Uwineza, F.I. (2017). Risk factors of Cholera transmission in rural areas in Haiti*. Med Sante Trop,* 27(1), 11-15*.*

Guillaume, Y.O., Gregory, T.I. & Raymond, M.I. (2019). Lived experience on epidermic cholera. *Journals of global Health.* 10(4), 11-36*.*

Kaiser B.N. & Foster, J.W. (2019). Cholera control and anti-Haiti stigma in the Dominican Republic. *Journal on Anthropol Medicine* 26(19), 123-141*.*

Mohammed, B.A. (2017). Cholera Mortality during Urban Epidermic, Dar Salaam, Tanzania. *Journal on public Health,* 23(7), 154-157.

Mutreja, A.O. & Dougan, G. I. (2020). Molecular epidemiology and intercontinental spread of Cholera. *Journals on health science*, 38(4), 46-51.

Talaei, M.B., Holakouie, N.K. & Masoumi, A.H. (2018). Knowledge, attitude and practice of people about foodborne outbreak in Isfahan city, Iran. *Journals on Food Hygiene*, 15(1), 39-45.

Orimbo, E.O., Oyugi E.O., Dulacha, D.A. & Obonyo, A. J. (2018). Knowledge, attitude and practices on cholera in an Arid country, Kenya. *Journals on Health science*. 15(2), 94-100.

World Health Organization (WHO). (2019). Cholera fact sheet. *http:/www.who.int/mediacentre/factsheet/fs107/en.*

World Health Organization (WHO). (2019). Vaccine Preventable Diseases Surveillance Standards.

World Health Organization (WHO) and United Nations Children Funds (UNICEF) (2019). Progression on Sanitation and Drinking Water.

14   **International Journal of Medicine, Nursing & Health Sciences (IJMNHS) ®**
(IJMNHS.COM)
Email: editor.ijmnhs@gmail.com   editor@ijmnhs.com   Website: ijmnhs.com

Published By

15 **International Journal of Medicine, Nursing & Health Sciences (IJMNHS) ® (IJMNHS.COM)**
Email: editor.ijmnhs@gmail.com   editor@ijmnhs.com   Website: **ijmnhs.com**

Published By